

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 01/20/2012	
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804			
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/20/12</p> <p>Facility Number: 000476 Provider Number: 155446 AIM Number: 100290870</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Covington Manor Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building consisting of the West wing, East wing, Bed and Breakfast unit and the service hall was surveyed with Chapter 19, Existing Health Care Occupancies.</p>		K0000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors. The facility has a capacity of 149 and had a census of 135 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/26/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K0029 SS=E	<p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 shower rooms in the Bed and Breakfast unit used for storage of soiled linen, therefore creating a hazardous area, was provided with a door that would self close and latch into the frame. This deficient practice could affect 23 residents in the Bed and Breakfast unit.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/20/12 at 12:45 p.m., two soiled linen barrels were stored in the Bed and Breakfast shower room. This shower room corridor door lacked a self closing device. Based on an interview with the Maintenance Director at the time</p>		K0029	<p>1. The identified door had a self closing device installed.</p> <p>2. All soiled linen storage rooms were reviewed for self closing devices</p> <p>3. Maintenance director will review these doors monthly to ensure they are in working order.</p> <p>4. Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter</p>		02/12/2012	

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	of observation, soiled linens are stored in these barrels until they are taken by the laundry staff to the laundry room. 3.1-19(b)						

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K0064 SS=E	<p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 K Class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining</p>		K0064	<p>1. The identified placard was purchased and installed</p> <p>2. There are no further extinguishers that meet this requirement</p> <p>3. Dietary staff will be in serviced on utilizing the fire protection system on the hood should be used prior to the extinguisher. The Maintenance Director will review the continual placement of the identified sign quarterly with his routine fire drills.</p> <p>4. Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter</p>		02/12/2012	

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	<p>room and all kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 01/20/12 at 1:35 p.m., the kitchen K Class fire extinguisher lacked a placard. Based on an interview with the Maintenance Director at the time of observation, the kitchen K Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic fire suppression system.</p> <p>3.1-19(b)</p>						

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K0147 SS=D	<p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 wet location resident care areas in the Bed and Breakfast unit such as the shower room and 1 of 3 staff medication rooms were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects any of the 23 residents in the Bed and Breakfast unit and any staff using the sink in the East wing nurses' station medication room in the event of an electrical short.</p>		K0147	<p>1. The identified GFCI plugs were installed</p> <p>2. All shower rooms and medication rooms were audited for any other required GFCI plugs</p> <p>3. The maintenance Director will maintain the functionality of these plugs as required</p> <p>4. Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter</p>		02/12/2012	

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	<p>Findings include:</p> <p>a. Based on observation with the Maintenance Director on 01/20/12 at 12:42 p.m., the Bed and Breakfast shower room had an electrical receptacle on the wall within three feet of a sink which was not provided with GFCI protection to prevent electric shock. Based on an interview with the Maintenance Director at the time of observation, he confirmed the circuit breaker for this outlet was also not provided with GFCI protection to prevent electric shock.</p> <p>b. Based on an observation with the Maintenance Director on 01/20/12 at 12:30 p.m., the East wing nurses' station medication room had an electrical receptacle on the wall within three feet of the hand sink which was not provided with GFCI protection to prevent electric shock. Based on interview with the Maintenance Director at the time of observation, he confirmed the receptacle was not on a GFCI breaker.</p> <p>3.1-19(b)</p>						

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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/20/12</p> <p>Facility Number: 000476 Provider Number: 155446 AIM Number: 100290870</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Covington Manor Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The new section of the building consisting of the Rehabilitation wing was surveyed with Chapter 18, New Health Care Occupancies.</p>		K0000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>			

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	<p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors. The facility has a capacity of 149 and had a census of 135 at the time of this survey.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K0051 SS=E	<p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors in the Rehabilitation wing electrical room was not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect any resident near the electrical room in the Rehabilitation wing.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on</p>		K0051	<p>1. The identified smoke detector was relocated the required distance from the vent 2. All electrical rooms were reviewed for any smoke detectors that are located too close to vents and were addressed as needed. 3. The maintenance director will continue to monitor any installation of future smoke detectors to ensure they are with in state guidelines 4. Results of audits will be forwarded to QA&A committee for tracking and trending monthly for 3 months then quarterly thereafter</p>		02/12/2012	

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	01/20/12 at 1:07 p.m., the Rehabilitation wing electrical room had a smoke detector located within three feet of an supply air duct. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)						